DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Emergency Medical Services Office
123 Chalan Kareta
Mangilao, GUAM 96913-6304
(671)735-7407 FAX (671) 735-7413

COURSE APPROVAL REQUEST

FOR OFFICE USE **vjq040612 / han042716**

Date Received & By: _____

Date Received & By: _____

/ / Approved / / Disapproved

_____
Marlene M. Carbullido, RN, MSN
EMS Administrator

Date: _____

TYPE OF COURSE
/ / EMD / / EMD Review
/ / EMT / / EMT Review
/ / AEMT / / AEMT Review

COURSE DATE:

From: _____ To: _____

COMMENTS: _____
_____
_____

Please Type or Print (Use Black or blue ink ONLY)

Requested By (Print Full Name): _____ **Position/Title:** _____ **SIGNATURE:** _____	**Sponsoring Agency:** _____ **Course Title:** _____ **Course Number:** _____ **Number of Hours:** _____
Course Coordinator (Print Full Name): _____ **SIGNATURE:** _____	**Meets U.S. DOT/NHTSA Training Standards:** / / Yes / / No
PRIMARY Lead Instructor (Print Full Name): _____ **SIGNATURE:** _____	**Number of Students (maximum – 24):** _____
SECONDARY Lead Instructor (Print Full Name): _____ **SIGNATURE:** _____	**Instructor Aide (Print Full Name):** _____ **SIGNATURE:** _____

COURSE APPROVAL REQUEST

Please attach the following documentation with this request. Documentation must be submitted one (1) month prior to review and approval with two copies (original and two copies):

1. **COURSE SCHEDULE: The schedule must include the dates, times, topics, lab schedules, quizzes, exams, as well as proposed commencement and completion dates for each course.**
2. **Training Objectives and Methodology**
3. **Course Outline**
4. **Documentation of sufficient and type of instructor materials. Documentation must include the name of the Instructor manual, resource materials, TV, VCR, videos, etc.**
5. **Type of Skills Manual to be used. A skills manual is highly recommended as a supplemental to the test**
6. **Textbooks and reference materials**
7. **Examination requirements**
8. **Equipment required. Documentation of your ability to maintain and acquire, if necessary, the equipment, materials and supplies necessary to conduct the course**
9. **A list of CERTIFIED Course Instructors**
10. **A copy of Memorandum of Agreement with the medical facility that will be providing the hospital clinical experience**
11. **Copies of ALL quizzes and exams**
12. **A final skills exam checklist. The checklist must include detailed steps and measurable outcome, as this practical exam is used in lieu of the skills practical for the Guam Exam.**

Course Director (Print Full Name):

_____

Signature: _____

Title: _____

Contact Number: _____

Sponsoring Dept/Agency Head (Print Full Name):

_____

Signature: _____

Title: _____

Contact Number: _____

NOTE

If the training institution / sponsoring department cannot fill their own Medical Director position then the DPHSS-EMS Medical Director will serve as the Acting Medical Director to ensure oversight for the EMT Course.

DPHSS-EMS Office Medical Director (Print Full Name):

_____

Signature: _____

Date: _____

Dept/Agency Medical Director (Print Full Name):

_____

Signature: _____

Date: _____